UNIVERSAL FRAMEWORK OF OBJECTIVES FOR HIV/AIDS

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Glossary of Terms and Abbreviations

AZT	Azidothymidine
HPN	Health, Population, & Nutrition
IDU	Infecting Drug Use
NACP	National AIDS Prevention and Control Programme
NGO	nongovernmental organization
PLWHA	Persons living with HIV and AIDS
SO	Strategic Objective
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	United Nations Joint and Co-sponsored Programme on AIDS

1. The Universal Framework Of Objectives (UFO)

1. What the Universal Framework of Objectives for HIV/AIDS Is

USAID's Universal Framework of Objectives for HIV/AIDS is a brand new tool, still under development, which has four main purposes:

1 Program planning and development, strategy formulation, monitoring and evaluation.

2 Analysis of existing programs and coordination, funding, resource flows.

3 To stimulate discussion with partners for participatory program planning.

4 Advocacy for program development and change.

It is an IDEAL PICTURE, a catalogue, a list, of all the things that could be done to combat the HIV/AIDS epidemic. The UNIVERSAL FRAMEWORK of OBJECTIVES is a tool for THINKING ABOUT the HIV/AIDS epidemic, EXPLORING POSSIBILITIES for dealing with it, and ORGANIZING WITH YOUR PARTNERS to BE EFFECTIVE in your work. Because little of what we know about some aspects of the epidemic has been codified or systematized, the framework will be constantly changed and updated as more is systematized and revealed.

A copy of this framework is included in the front packet of this workbook. This draft of the framework was developed by a participatory planning team which included:

- USAID Mission personnel (HPNs, HIV/AIDS advisors)
- USAID Global Health and HIV/AIDS personnel
- External experts at the global level (e.g., UNAIDS, UNDP, World Bank)
- External HIV/AIDS experts at the country level (e.g., NACP managers, UN program personnel).

The team started their work in 1995 and finished late in June, 1996. Their task? To identify all possible HIV/AIDS prevention, care and mitigation interventions which could be undertaken in the "best of all possible worlds". They prepared the draft which you see here.

2. What the Universal Framework of Objectives for HIV/AIDS Is Not

It is not:

- ImMUTE-able
- UnCHANGE-able
- The LAST WORD in HIV/AIDS programming.

It needs YOUR INPUT, so start scribbling on these papers, cutting them apart, moving them around and WORKING WITH THEM! And please let us know what you come up with!

3. Use in Program Development and Planning

The Universal Framework of Objectives has four main applications:
1. Planning

The first is in program planning and development, strategy formulation, monitoring and evaluation. The Mission can compare its current program elements with the Universal Framework of Objectives to identify new programming areas for consideration in the next generation of programming. For purposes of strategic planning, the Mission can examine geographic distribution of programs and demographic trends in epidemic impact to determine if vulnerable populations are

emerging for whom there are currently no programming resources. Rough worksheets for conducting geographic analyses are provided at the end of Chapters II through VI of this work book. For monitoring and evaluation purposes, the mission can determine if activities at lower levels of the Framework are having the desired impact on strategic objectives and purposes at the higher level of the framework. On the global level, the Framework will allow the Agency to identify and compare programming in individual countries for a more comprehensive understanding of the universal fit of USAID programming and epidemic phases. For example, are the objectives of reduction of HIV transmission or preservation of community well being and work site productivity being achieved through current STI screening programs, counseling and support interventions, and expansion of workplace capacity for prevention?

2. Analyzing

The second use for the UFO is to analyze existing programs, funding, and resource flows so you can allocate resources more efficiently. After determining what programs are currently being funded or are planned by the Mission, the government, and other donors; the Mission can determine what program gaps exist and who is best positioned to fill them. A draft worksheet for completing this analysis appears at the end of Chapters II through VI. This analysis can be completed for the country overall, or for specific geographic areas. Through program analysis in smaller geographic areas, the Mission can also identify new programming opportunities and partners by examining the distribution of worksite, community, and NGO activities on the Universal Framework.

The worksheets can also be used to compare options for total resource investment according to the stage of the epidemic and the anticipated impact of current investments. In this way, investment levels by program type can be reallocated according to future anticipated impact of the epidemic. For example, if it can be anticipated that a country will have a large population of orphans or vulnerable families, the mission can determine if current and planned investments in services for these populations will be sufficient.

3. Participation

After programmatic distribution and investment levels are analyzed, the Framework can be used to stimulate discussion with partners for participatory program planning. The Mission can develop geographic and programmatic analyses alone or jointly with its partners in order to communicate and coordinate programming options. The Universal Framework can be used to facilitate joint planning processes because it displays all possible programming options. It also

promotes more objective appreciation of the importance of each of the partners' contributions because their interrelationships are better understood.

4. Advocacy

Advocacy for program development and change. The Universal Framework of Objectives allows the Mission to readily identify country programming gaps and work with partners to develop plans to meet them. In certain important areas of program development illustrated by the Framework, advocacy for legal development and fundamental social change may be required, either with the government or with vulnerable populations and communities. The Framework provides a convenient tool for visualizing the impact of social change on epidemic spread and mitigation and communicating that understanding to Mission partners at any level of intervention.

4. What Are the Framework's Parts?

The Universal Framework of Objectives has 5 levels. The levels of the Framework are causally related, which means that actions taken at the lower levels will influence outcomes at higher levels. These causal relationships are designated by the connecting lines. If, for example, a program results in reduction of risky sexual behavior and reduction of the prevalence and duration of sexually transmitted infections, the transmission of HIV/AIDS will be reduced (Strategic Objective 1). If enabling services such as child care and credit services are provided for vulnerable populations or their access to services is increased, their productivity will be increased and economic security enhanced (Strategic Objective 2). In developing or revising program designs, observations of these relationships will help identify likely program outcomes and develop useful indicators for measuring their achievement. The levels of the Framework are:

Level 1. The USAID Worldwide Mission

- To promote sustainable development

Level 2. USAID Global Goals

- To encourage broad based economic growth
- To encourage democracy building

- To protect human health.

Level 3. USAID Mission (Country Level) Goals

In the Health Sector, the broad goals in HIV/AIDS-related programming are to reduce the impact of HIV/AIDS on:

- Individual and family health and welfare
- The health sector
- The productive sector
- Community welfare
- Social and political instability.

Level 3 of the Framework identifies the many areas in which the impact of the epidemic will be felt:

1. Individual and Family Health and Welfare Impacts

Most USAID missions have devoted the bulk of their attention to programming which addresses individual and family impacts of HIV/AIDS. This is a result of the fact that the epidemic has been visualized in the past as largely a medical and behavioral problem. Among the most apparent of these are:

- Sickness and death
- Need for care
- Loss of income
- Loss of productivity
- Decline in agricultural output
- Reductions in nutrition
- Breakup of families
- Increased dependency ratios and pressure on surviving adults caring for additional family members

- Psychological losses and burdens related to sickness, death, decline in well being and increased insecurity
- Loss of the family's adult members at their most productive ages.

2. Health Sector Impacts

As medical and behavioral programs have proven to have limited success in stopping or even slowing viral spread in many countries, more attention has been given over the past five years to understanding how an epidemic generates larger and more serious social and economic problems. In addition, as the epidemic becomes more widespread, the deleterious consequences it will have on social and economic development are becoming more and more apparent. Among the impacts which many countries are experiencing in the health sector are the following:

- Health resources such as hospital beds, drugs, and home care are increasingly absorbed in providing care for persons with HIV/AIDS, reducing the amount of resources which can be spent on other health problems
- Interaction of HIV/AIDS and other diseases, such as tuberculosis
- Reversal of gains in reducing infant and child mortality
- Increased adult mortality
- Loss of vital health sector personnel
- Demoralizing effects of increased mortality and absorption of resources.

3. Productive Sector Impacts

Other sectors of the economy will be affected by serious increases in epidemic mortality just like the health sector. These include:

- Loss of manpower in vital industrial sectors
- Loss of manpower in subsistence and commercial agriculture and declines in agricultural land base
- Loss of personnel in social sectors, including education and social services.

4. Community Welfare Impact

In some areas, declines in individual and family well being and the outputs of vital productive sectors will lead to overall declines in community well being. Some of the impacts which may be felt include the following:

- Decline in availability of social services
- Loss of jobs and productive potential
- Loss of community coherence
- Loss of traditions and rituals.

5. Social and Political Stability.

Advance of the epidemic has serious implications for social and political stability, including:

- Population shifts from mortality and migration
- Loss of income with increased investment in social services
- Increase in the number of unaccompanied children orphaned by the epidemic.

Level 4. Mission (Country Level) Strategic Objectives

Level 4 of the Universal Framework of Objectives identifies Strategic Objectives (SOs) for program planning and design. These are areas of activity which the Mission can approach through specific programs and from which project accomplishments can be measured against. The range of possible objectives for HIV/AIDS programs identified in the Framework include the following:

- To reduce the transmission and acquisition of HIV
- To maximize the productivity and security of vulnerable populations
- To catalyze and sustain community ownership of HIV/AIDS programs
- To redress human resource losses resulting from HIV/AIDS
- To reduce stigmatization and discrimination against populations vulnerable to HIV/AIDS and ensure that their human rights are protected.

Level 5: Mission (Country Level) Program Results

In the program planning process, USAID mission programs identify desired results for HIV/AIDS programs. Project accomplishments will be evaluated to determine if they achieve the desired results identified in the plan. Possible results a country might want to accomplish in HIV/AIDS programming are shown on Level 5 of the Universal Framework of Objectives, and include the following:

Program Results 1: HIV Transmission

- Sexual Risk behavior and situations are reduced
- Prevalence and duration of sexually transmitted infections (STIs) are reduced
- Families and women make informed pregnancy choices
- IDU risk behavior is reduced
- Therapies to reduce infectivity are used
- Safe blood supplies are sustained
- Occupational Use of universal precautions is sustained
- Other parenteral risk behavior is reduced
- Preventive vaccines are used by all.

Program Results 2: Productivity and Security of Vulnerable Populations

- Vulnerable populations use productive resources
- Effective support, counseling, care and health services are provided to PLWHAs, Their families, and affected communities.

Program Results 3: Community Ownership

- Financial resources are available at community level
- Societal and community awareness is increased
- Community participation in HIV/AIDS programming is ensured
- Community competencies are recognized
- Community skills are enhanced.

Program Results 4: Human Resource Losses

- Workplace initiatives are catalyzed and sustained
- Training and educational systems are re-oriented to respond to forecasted gaps
- Appropriate redistributions of labor are facilitated.

Program Results 5: Stigma, Discrimination, and Human Rights

- Supportive laws and policies are developed, strengthened, implemented and enforced
- Understanding of HIV transmission and personal vulnerability is increased
- Community members and leaders advocate and practice nondiscriminatory and supportive behaviors
- Recognition and acceptance of intra-societal differences are increased
- Independent and effective monitoring systems are established and sustained.

Remember: In all cases, the Framework describes the range of possibilities. Not all HIV/AIDS programs will or should have all these components. Careful program design, using the Universal Framework of Objectives, will identify the best mix of possible actions for your country setting. The mix will be determined by a number of factors, including the stage of the HIV/AIDS epidemic in the country, as well as available resources for program development and implementation.

5. How are the Levels Interrelated?

Levels of the Framework are linked:

- **Causally**
- **By stage of the epidemic**
- **By investment choices**

1. Causal Links

Levels of the Universal Framework of Objectives are linked causally, that is to say, actions undertaken on one level will lead to outcomes on the next level up. These logical relationships can be built into program plans on the country level. For

example, in countries where the epidemic mortality has reached high levels, it may be important to reduce health system and productive sector impacts. Health–related and professional psycho-social resources may be exhausted or severely strained, and industries and commercial farms may be experiencing drains on personnel. Under these conditions, it becomes important to strengthen community resources for home–based care for persons living with HIV/AIDS and for their survivors. Program interventions on Level 5 can be linked with the intention of causing changes at the system and impact levels.

2. Program Emphasis and the Stage of the Epidemic

Four of the Program Results Groups (4.2 to 4.5) shown in the framework address mitigation of the epidemic's impact. Most missions have devoted their attention to the first set of Program Results: reduction of transmission and prevention of the spread of the HIV/AIDS virus. Some missions have a little experience with support, counseling, and care programs, and also with work site based prevention and mitigation programs. The boxes under the first Program Results Groups, each of which identify an approach to slowing or stopping transmission, are more numerous and better detailed because this is the area where most program experience exists. As experience develops with other aspects of the epidemic, it is likely that our ability to flesh out the remaining objectives in the Framework will improve vastly.

FIGURE 1: OBJECTIVES IN THE FRAMEWORK

Early	Middle	Late
Prevention	Care and Counseling	Survivor Support
	Community Competency	Productivity Enhancement
		Social Stability

In general, prior programs emphasized the problems countries were experiencing during the early stage of the epidemic curve—when their programs were initiated. Programs developed earlier in the epidemic will place most emphasis on prevention. When epidemic mortality increases, emphasis will shift to supporting programs which provide care and counseling for persons with HIV/AIDS. Finally, as deaths accelerate, programs to support vulnerable populations (widows and orphans) will increase in importance and become more visible. Programs to

maintain productivity and social stability also increase in importance as epidemic mortality increases.

3. Investment Choices

A Mission can use the Universal Framework of Objectives to map the balance of their investments in HIV/AIDS programming. The balance of investment by Results Group will effect outcomes not only within that Group, but will have effects on other Groups. Each HIV/AIDS program is like a portfolio, where outcomes are slightly unpredictable and hopefully symbiotic. The worksheet on the following page might help you think through some of these interconnections.

The worksheet is designed to help you ask two important questions:

- What does your current portfolio look like? Does it address any anticipated program impacts outside the health sector?
- Will your program serve you well through the coming stages of the epidemic? Should it be modified to anticipate increased epidemic mortality over the next five to ten years?

As you note the relationship between the Mission's current HIV/AIDS programming and the current and future epidemic stage in your country, think how you could modify your current programming to be more relevant to future epidemic stages.

4. What's Next?

In Chapter II you'll find instructions on the use of the geographic and donor worksheets contained in Chapters III through VII.

In Chapters III through VII, you'll find a more complete description of each Program Results Group and sample results packages, as well as program, geographic, and donor worksheets to help you explore your current situation and future plans in more detail.

TABLE 1. EPIDEMIC STAGE WORK SHEET

Program Results Group	Program	Epidemic Stage When Program was Initiated	Current/Future Epidemic Stage
Transmission/Acquisition	Sexual Behavior		
	STIs		
	Pregnancy		
	IDU		
	Infectivity		
	Blood Supplies		
	Occupational		
	Parenteral		
	Vaccines		
Vulnerable Populations	Resource Use		
	Support Programs		
Community Ownership	Financing		
	Awareness		
	Participation		
	Competencies		
	Skills Developed		
Human Resource Losses	Workplace Programs		
	Training		
	Labor Redistribution		
Discrimination	Laws and Policies		
	Awareness		
	Leadership		

	Acceptance		
	Monitoring		

2. Instructions for Using the Worksheets

1. How to Use the Universal Framework of Objectives Workbook Chapters

Each System Objective and corresponding Result Group included in the Universal Framework of Objectives is broken in the chapters that follow:

Chapter III: Transmission and Acquisition of HIV/AIDS are Reduced
Chapter IV: Productivity and Security of Vulnerable Populations is Maximized
Chapter V: Community Ownership of HIV/AIDS Responses is Catalyzed and Sustained
Chapter VI: Human Resource Losses Due to HIV/AIDS are Reduced
Chapter VII: Stigmatization and Discrimination Against Populations Vulnerable to HIV/AIDS are Reduced and Their Human Rights Protected

At the of each of the chapters, you will find a more complete description of the program results (Level 5) necessary to achieve the system of objectives on Level 4.

In addition, there are three types of tables designed to help you analyze your HIV/AIDS programming activities:

- Implementation and investment analysis tables
- Geographic planning tables
- Donor analysis worksheets

The implementation and investment analysis tables are designed to help you take a closer look at the content of your current or future program. The table encourages you to note:

- The approaches being taken by your project to achieve the results desired.

- The implementation mechanisms being used, e.g, NGOs, government offices, coordination with other donors.

- The amount you are currently investing or intend to invest in the future.

After you complete the worksheet for each section, you can consolidate the results to determine if your investments are balanced or if you are utilizing as broad a range of implementation mechanisms as possible.

The geographic planning table encourages you to take a look at the coverage you are attaining in each programmatic area. To use the table, enter the name of each geographic area in the country where you are working, then note project coverage with check marks or other notations. This information can also be transferred to map for a quicker visual presentation of the same data.

The donor analysis worksheet is the last of the set. It lets you compare your programs with those of other donors, and look at the completeness of coverage implied by overall donor support. You might want to fill these tables out in collaboration with your partners.

2. Other Uses for the Framework

In addition to the uses described above for the framework, you can also us it to stimulate discussion with your national government's AIDS program to determine the coverage of current plans and possible gaps to be addressed in future programming. The national AIDS control plan can be mapped against the UFO to identify areas of emphasis and gaps, or to create a "national UFO" describing programming in you country at a glance.

In all applications, the UFO makes it easy to examine overlaps in activities and the potential synergy of activities in nonhealth sectors more easily.

3. System Objective 1: Transmission and Acquisition

4.1 Transmission and Acquisition of HIV is Reduced

5.1.1. Sexual Risk Behavior and Situations are Reduced

The bulk of resources spent in Mission programming has gone into attempting to change human sexual behavior to reduce the opportunity for viral spread. The most familiar of these methods is condom promotion; perhaps the most frustrating is behavior change communication—health education which attempts to enable individuals to alter risk taking behavior to reduce their exposure to transmission. In addition, several other illustrative examples are included here: widening the availability of barrier methods available in a country to include such alternatives as the female condom, and increasing knowledge levels so sexually active persons are more aware of their possibilities for protection and to convince them of the importance of using them.

5.1.2. Prevalence and Duration of STIs are Reduced

It is widely recognized that presence of a sexually transmitted infection can increase the likelihood of successful HIV transmission in any sexual contact, and recent evidence suggests that reduction of other STIs can reduce transmission by up to 42 percent. In many developing countries, services for STI diagnosis and treatment are poor, so great gains in reducing spread of HIV can be made by improving STI services through training in effective case management; widespread availability of screening programs; provision of drugs and adequate infrastructure; and effective education programs which encourage individuals to seek screening, diagnosis and treatment. In addition, in several areas, the effectiveness of mass treatment programs, where all individuals in an area receive treatment, is currently being tested.

5.1.3. Families and Women Make Informed Choices Regarding Pregnancy

With vertical transmission rates of 25 to 30 percent in developing countries, many HIV/AIDS cases could be averted if HIV positive women, their spouses, and families understood this risk of pregnancy and child bearing. Individual and family

counseling to assist women making difficult choices about pregnancy is not widely available in developing countries and can be expanded. In addition, women need to be empowered to make informed pregnancy choices and carry them out. In a wider perspective, increased availability, accessibility, and affordability of reproductive health services could serve as a platform for improved counseling, diagnosis, and treatment of STIs; and availability of barrier methods of contraception for reduction of viral transmission.

5.1.4. Intravenous Drug Using (IDU) Risk Behavior is Reduced

Risky intravenous drug using behavior can contribute to the spread of HIV among drug users and to their families. Possible interventions include expanded assistance to drug users who wish to stop drug use. Other options, adopted by some countries of the world, include provision of needle exchange programs so the risk of transmission from drug use and needle sharing is reduced. Alternatively, drug users can be educated to clean their needles so transmission is reduced. Lastly, effective education programs can increase the accuracy of drug users' perception of their personal risk and the risk which they might be creating for their families.

5.1.5. Therapies to Reduce Infectivity are Used by Infected Populations

Once an individual is infected with the HIV virus, adoption of measures which reduce their infectivity to others can contribute to reduction in viral transmission. Although many approaches are under development, much of this technology remains to be developed. Where available, provision of AZT therapy can reduce risk of transmission of the virus from mother to child when a women is HIV positive. Other therapies may become available which will also reduce risk. The factors influencing infectivity need to be researched and therapies need promotion and development. Once available, educational programs will become necessary to help infected individuals understand their risks and avoid transmission to others.

5.1.6. Safe Blood Supplies are Sustained

Thanks to widespread efforts early in the epidemic, countries have ensured the safety of their blood supplies. It remains critical that the safety of blood supplies be sustained through maintenance of effective screening programs, and that efforts

to develop deferral strategies so infected individuals avoid blood donation are continued. In addition, guidelines for rational use of blood products need further development so unnecessary transfusions are avoided.

5.1.7. Occupational Use of Universal Precautions are Sustained

Risk of transmission to health care workers needs to be minimized as fully as possible in situations of surgery, patient care, laboratory testing, and family or professional home care. It is important to increase health care worker awareness and knowledge so unnecessary exposure is avoided and infection control policies are strengthened. In many countries, protective equipment is in short supply and is not well distributed. Where possible, strategies for developing indigenous and alternate supplies and improving distribution will contribute to the protection of the safety of health care workers.

5.1.8. Other Parenteral Risk Behavior is Reduced

Some traditional practices, including decorative and ceremonial tattooing and skin piercing, may contribute to viral transmission if not conducted hygienically. It is important to increase the understanding of practitioners of the risks involved in these practices, and to establish, where possible, constructive risk reduction policies. Distribution of safer tools and supplies can help traditional practitioners and their clients ensure risk free approaches.

5.1.9. Preventive Vaccines are Used By All

Although early efforts to develop preventive vaccines were disappointing, work still continues to develop and test effective vaccines. Globally, efforts need to be sustained to develop low costs vaccines which are appropriate for use in low income settings. Once available, it will be necessary to increase public awareness of the benefits of vaccines, promote their widespread distribution, and encourage their use.

FIGURE 2

4.1 TRANSMISSION AND ACQUISITION

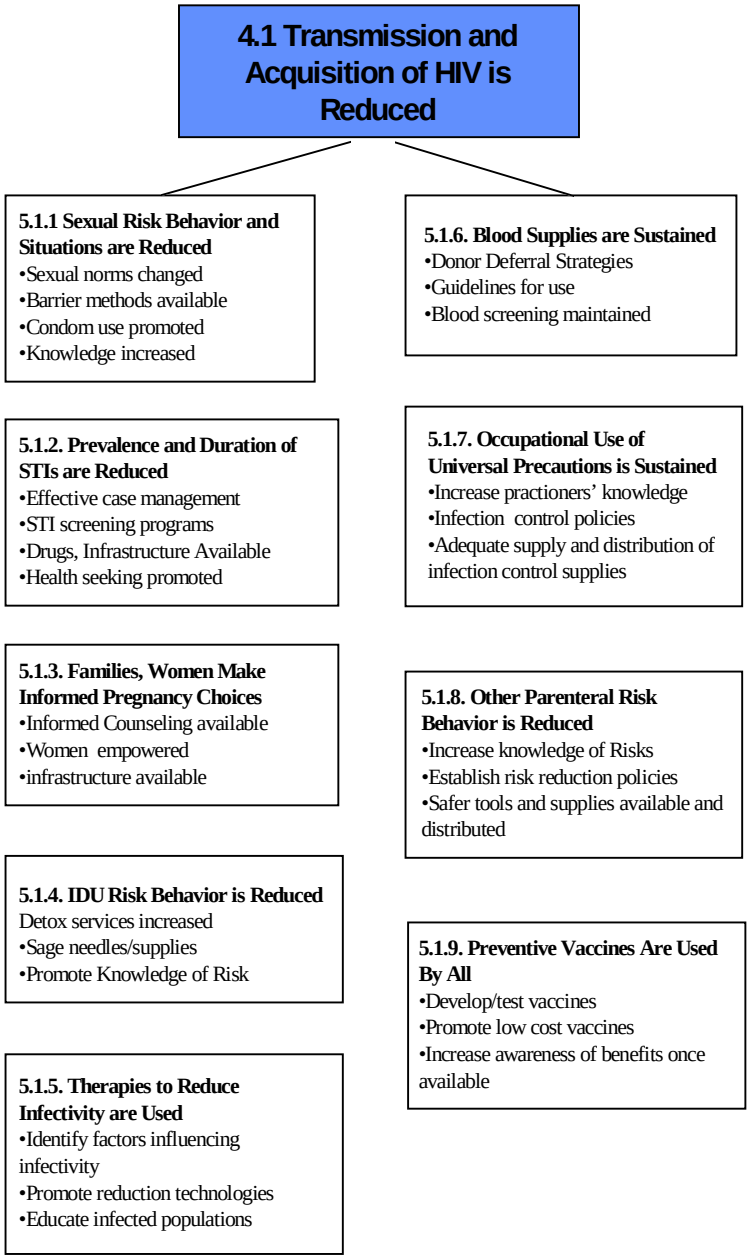

TABLE 2. IMPLEMENTATION AND INVESTMENT ANALYSIS: SEXUAL TRANSMISSION

Sexual Transmission Reduced	Approach	Implementation Mechanisms	Amount Invested
Change in Sexual Behavior			
STI Reduction			
Pregnancy Counseling			
IDU			
Parenteral Infection			
Blood Supplies			
Occupational Infection			
Infectivity/Vaccines			

TABLE 3. TRANSMISSION AND ACQUISITION: GEOGRAPHIC PLANNING

Reduce Transmission	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
1. Sexual Risk Behavior									
Sexual Norms Changed									
Barrier Methods Available									
Condom Use Promoted									
Knowledge Increased									
2. STIs Reduced									
Effective Case Management									
STI Screening Programs									
Drugs, Infrastructure Available									
Health Seeking Promoted									
3. Informed Pregnancy Choices									
Counseling Available									
Women Empowered									
Infrastructure Available									
4. IDU Risk Behavior									

Reduce Transmission	**National**	**Area 1**	**Area 2**	**Area 3**	**Area 4**	**Area 5**	**Area 6**	**Area 7**	**Area 8**
Detox Services Increased									
Safe Needles/Supplies									
Promote Knowledge of Risk									
5. Reduce Infectivity									
Identify Factors									
Promote Reduction Technology									
Education Infected Persons									
6. Sustain Safe Blood Supplies									
Donor Deferral Strategies									
Guidelines for Use									
Blood Screening Maintained									

TABLE 4. TRANSMISSION AND ACQUISITION: INDICATOR PLANNING

Reduce Transmission	**National**	**Indicator 1**	**Indicator 2**	**Indicator 3**	**Indicator 4**	**Indicator 5**	**Indicator 6**	**Indicator 7**	**Indicator 8**
1. Sexual Risk Behavior									
Sexual Norms Changed									
Barrier Methods Available									
Condom Use Promoted									
Knowledge Increased									
2. STIs Reduced									
Effective Case Management									
STI Screening Programs									
Drugs, Infrastructure Available									
Health Seeking Promoted									
3. Informed Pregnancy Choices									
Counseling Available									
Women Empowered									
Infrastructure Available									
4. IDU Risk Behavior									

Reduce Transmission	**National**	**Indicator 1**	**Indicator 2**	**Indicator 3**	**Indicator 4**	**Indicator 5**	**Indicator 6**	**Indicator 7**	**Indicator 8**
Detox Services Increased									
Safe Needles/Supplies									
Promote Knowledge of Risk									
5. Reduce Infectivity									
Identify Factors									
Promote Reduction Technology									
Education Infected Persons									
6. Sustain Safe Blood Supplies									
Donor Deferral Strategies									
Guidelines for Use									
Blood Screening Maintained									

TABLE 5. TRANSMISSION AND ACQUISITION: DONOR ANALYSIS WORKSHEET

Reduce Transmission	Donor 1	Donor 2	Donor 3	Donor 4	Donor 5	Donor 6	Donor 7	Donor 8
1. Sexual Risk Behavior								
Sexual Norms Changed								
Barrier Methods Available								
Condom Use Promoted								
Knowledge Increased								
2. STIs Reduced								
Effective Case Management								
STI Screening Programs								
Drugs, Infrastructure Available								
Health Seeking Promoted								
3. Informed Pregnancy Choices								
Counseling Available								
Women Empowered								
Infrastructure Available								
4. IDU Risk Behavior								
Detox Services Increased								

Reduce Transmission	**Donor 1**	**Donor 2**	**Donor 3**	**Donor 4**	**Donor 5**	**Donor 6**	**Donor 7**	**Donor 8**
Safe Needles/Supplies								
Promote Knowledge of Risk								
5. Reduce Infectivity								
Identify Factors								
Promote Reduction Technology								
Education Infected Persons								
6. Sustain Safe Blood Supplies								
Donor Deferral Strategies								
Guidelines for Use								
Blood Screening Maintained								

4. System Objective 2: Vulnerable Populations

4.2 Productivity and Security of Vulnerable Populations is Maximized

5.2.1. Vulnerable Populations Use Productive Resources

Persons living with HIV/AIDS (PLWHA) and their families often suffer loss of social and economic ability in addition to loss of their health. Some of these losses arise because their neighbors, employers, and communities do not understand the realities of HIV transmission and their own risks of infection. It is important that PLWHAs are protected from unnecessary losses through discrimination. In addition, families affected by HIV/AIDS, either through sickness or death, may need short-term assistance to recover their productivity and income losses which may have been suffered during long-term illness and death. Provision of services such as revolving credit funds and child care have proven to be effective and recoverable investments which reduce later demand on social support systems. Where available, vulnerable individuals and families need to be informed of services which can help them recover their productivity and income security. Training and educational resources for individuals and families can also help increase or sustain future productivity and income security and may need to be expanded.

5.1.2. Effective Support, Counseling, Care and Health Services are Provided to PLWHAs, Their Families and Affected Communities

Individuals and families affected by AIDS can often better maintain their productivity longer through illness and death and ensure the future well being of their survivors if they are provided necessary counseling, information, and support. Where possible, support services providing care and counseling, formal and informal, need expansion, and families need to be better apprised of their existence. Informal social and psychological care can be strengthened and expanded to widen coverage at low cost. Lastly, the privacy of individuals and families and their access to care and counseling, needs to be protected through provision of nondiscriminatory laws and policies.

Figure 3

Figure 3

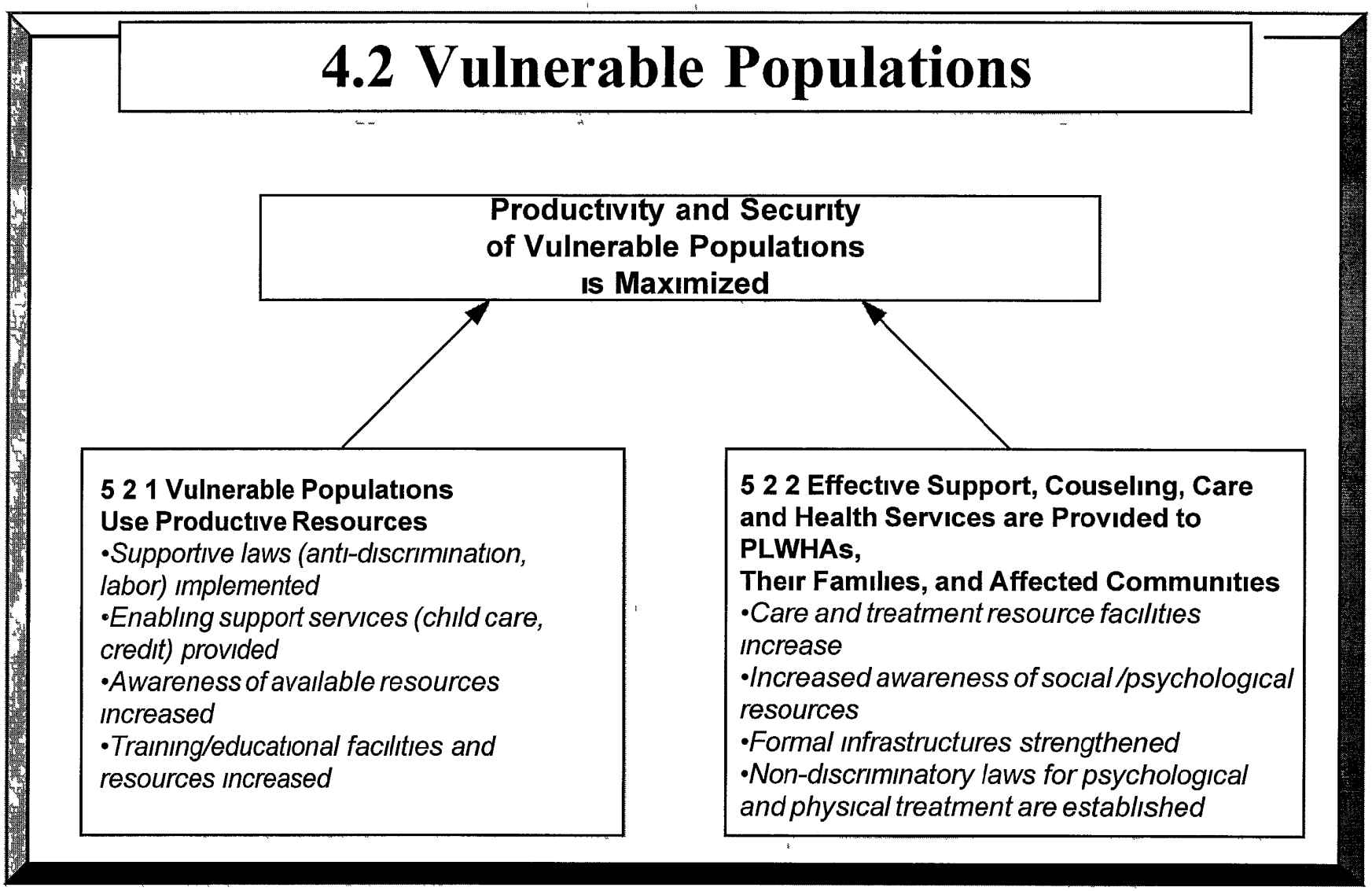
4.2 Vulnerable Populations
Productivity and Security of Vulnerable Populations is Maximized
5 2 1 Vulnerable Populations Use Productive Resources
•Supportive laws (anti-discrimination, labor) implemented
•Enabling support services (child care, credit) provided
•Awareness of available resources increased
•Training/educational facilities and resources increased
5 2 2 Effective Support, Couseling, Care and Health Services are Provided to PLWHAs, Their Families, and Affected Communities
•Care and treatment resource facilities increase
•Increased awareness of social /psychological resources
•Formal infrastructures strengthened
•Non-discriminatory laws for psychological and physical treatment are established

TABLE 6. IMPLEMENTATION AND INVESTMENT ANALYSIS: VULNERABLE POPULATIONS

Vulnerable Populations Protected	Approach	Implementation Mechanisms	Amount Invested
Productive Resources Used			
Effective Support Services			

TABLE 7. VULNERABLE POPULATION: GEOGRAPHIC PLANNING

Vulnerable Populations	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
1. Use Productive Resources									
Supportive Laws									
Enabling Supportive Services									
Public Awareness									
Training Facilities Available									
2. Family Services Available									
Care and Treatment Resources									
Public Awareness									
Informal Infrastructure									
Nondiscriminatory Laws									

TABLE 8. VULNERABLE POPULATIONS: INDICATOR PLANNING

Vulnerable Populations	National	Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8
1. Use Productive Resources									
Supportive Laws									
Enabling Supportive Services									
Public Awareness									
Training Facilities Available									
2. Family Services Available									
Care and Treatment Resources									
Public Awareness									
Informal Infrastructure									
Nondiscriminatory Laws									

TABLE 9. VULNERABLE POPULATIONS: DONOR ANALYSIS WORK SHEET

Vulnerable Populations	Donor 1	Donor 2	Donor 3	Donor 4	Donor 5	Donor 6	Donor 7	Donor 8
1. Use Productive Resources								
Supportive Laws								
Enabling Supportive Services								
Public Awareness								
Training Facilities Available								
2. Family Services Available								
Care and Treatment Resources								
Public Awareness								
Informal Infrastructure								
Nondiscriminatory Laws								

5. System Objective 3: Community Ownership

4.3 Community Ownership of Effective Responses to HIV/AIDS Are Catalyzed and Sustained

5.3.1. Specific and Adequate Financial Resources are Available at the Community Level for Effective Responses to HIV/AIDS

As epidemic mortality increases, the number of individuals and families who need support and care may increase and their needs will grow far beyond the ability of professional services and systems to provide them. Community-based organizations are already providing the bulk of services and care in many developing countries, and their work needs to be sustained and expanded. To enable this to happen, financial resources must be made available at the community level so resources can be built, sustained, and expanded. Mechanisms have been developed to channel resources for community use and monitor their effectiveness. In addition, attention needs to be paid to developing local resources, financial and in kind, so community-based assistance can be sustained. Finally, development of the ability of community-based organizations to assess their financial needs and report to donors needs to be strengthened.

5.3.2. Societal and Community Awareness and Understanding of the Impact of HIV on Community Survival and Well-Being is Increased

Various mechanisms for increasing community awareness of epidemic impact have been developed, including enumeration of vulnerable populations. Communities have also demonstrated the ability to examine and change traditional practices. As awareness grows and impact is felt more deeply, community ability to develop innovative responses will increase. The social role of PLWHAs in building community awareness can be locally recognized and valued. Communities with access to HIV surveillance data and case numbers will also be more easily mobilized.

5.3.3. Community Participation in the Design, Implementation, and Evaluation of HIV/AIDS Programs is Ensured

For communities to increase their awareness of the impact of the epidemic and their ability to respond to mitigate its impact and reduce viral spread, financially and psychologically, community participation in program design must be ensured. In many developing countries, communities have not only participated, but have taken the lead in initiating innovative, low cost responses in care, counseling, and provision of family support. Since the epidemic is long term, community responses must be designed so they are sustainable and affordable. In addition, communities must understand and direct evaluation of the effectiveness of their inputs and the implementation of their programs. Much more needs to be known about how innovative efforts can be encouraged and supported so their sustainability is ensured. Possible approaches include the identification and support of leaders to facilitate broad-based community participation and development of networks within and between communities to increase participation. Lastly, groups at the national level can ensure that supportive environments for community participation exist among political leaders and donors.

5.3.4. Governments, Donors, and "Experts" Use Community Competencies in the Identification and Definition of HIV/AIDS Issues and Problems

Governments, donors, and HIV/AIDS experts are expanding their ability to appreciate the innovativeness and commitment of communities to develop, implement, and sustain programs for HIV/AIDS prevention and care. This understanding is likely to increase as the epidemic's impact grows because communities will have to assume more and more responsibility for developing responses. Possible approaches to increase use of community competencies include expansion of opportunities for participation in planning and program design, and provision of training in approaches to implementation, evaluation, and monitoring. Donor project officers can immerse themselves in local activities to better understand how to facilitate and use community inputs.

5.3.5. Community Skills in Advocacy, Resource Mobilization, and Management Are Enhanced

Training and engagement of communities to build skills in advocacy, resource mobilization, and management will improve their ability to design, implement and evaluate programs which they undertake. In several countries, these skills have

been provided through community counseling programs. In addition, many NGOs and CBOs work to build community competencies for program provision. Such efforts need to be expanded and promoted if sustainable community responses are to be supported and expanded. In many cases, involvement of PLWHAs in NGO networks will develop and sustain their advocacy skills.

Figure 4

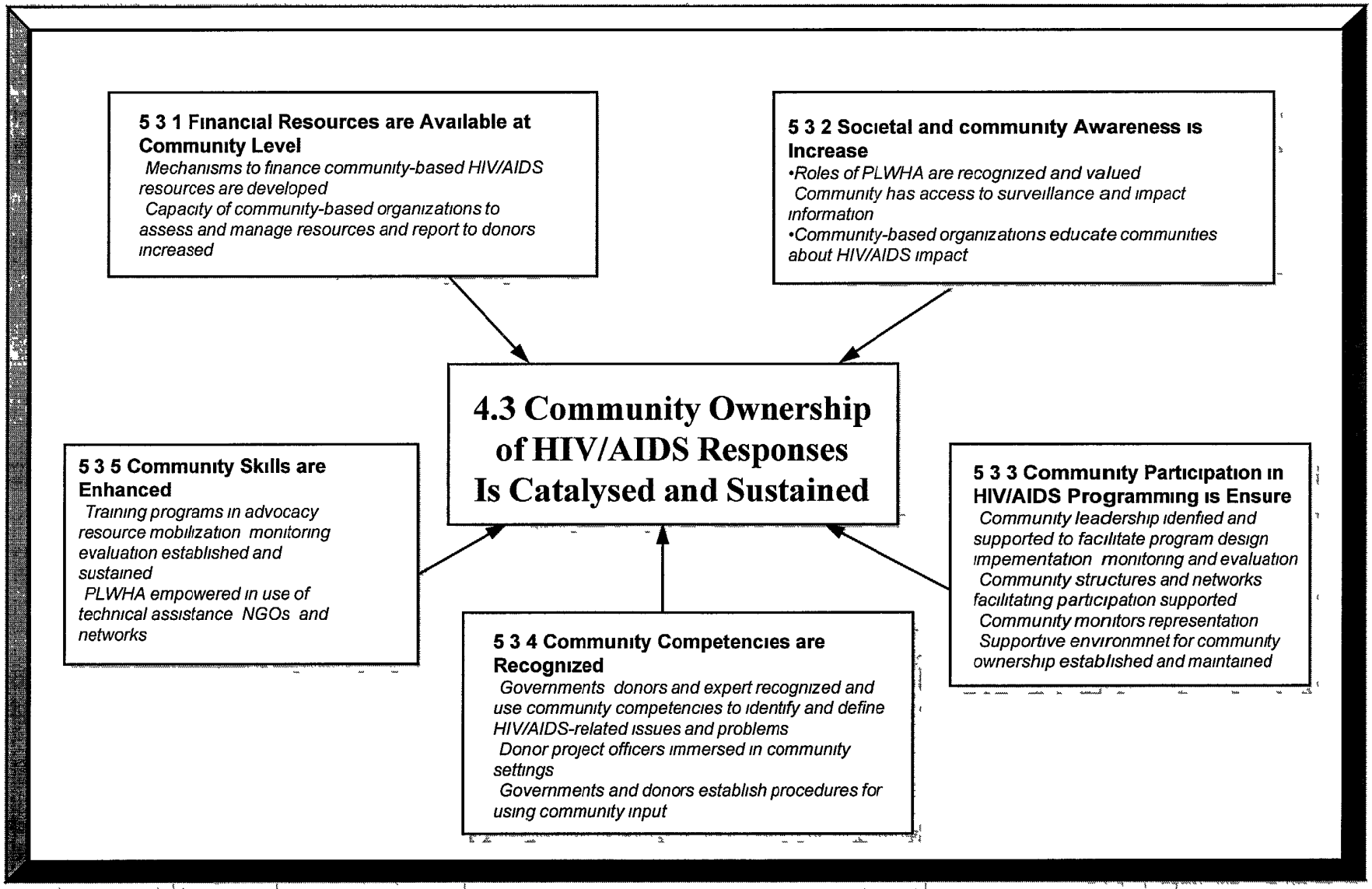
5 3 1 Financial Resources are Available at Community Level
Mechanisms to finance community-based HIV/AIDS resources are developed
Capacity of community-based organizations to assess and manage resources and report to donors increased
5 3 2 Societal and community Awareness is Increase
•Roles of PLWHA are recognized and valued
Community has access to surveillance and impact information
•Community-based organizations educate communities about HIV/AIDS impact
4.3 Community Ownership of HIV/AIDS Responses Is Catalysed and Sustained
5 3 5 Community Skills are Enhanced
Training programs in advocacy resource mobilization monitoring evaluation established and sustained
PLWHA empowered in use of technical assistance NGOs and networks
5 3 3 Community Participation in HIV/AIDS Programming is Ensure
Community leadership idenfied and supported to facilitate program design impementation monitoring and evaluation
Community structures and networks facilitating participation supported
Community monitors representation
Supportive environmnet for community ownership established and maintained
5 3 4 Community Competencies are Recognized
Governments donors and expert recognized and use community competencies to identify and define HIV/AIDS-related issues and problems
Donor project officers immersed in community settings
Governments and donors establish procedures for using community input

TABLE 10. IMPLEMENTATION AND INVESTMENT ANALYSIS: COMMUNITY OWNERSHIP

Community Ownership Increased	Approach	Implementation Mechanisms	Amount Invested
Financial Resources Available			
Awareness Increased			
Program Participation			
Community Competencies Recognized			
Skills Enhanced			

TABLE 11. COMMUNITY OWNERSHIP: GEOGRAPHIC PLANNING

Increase Community Ownership	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
1. Financial Resources Available									
CBO Financing Available									
CBO Capacity Increased									
2. Community Participation									
Leadership Supported									
Community Infrastructure									
Community Monitors									
Supportive Environment									
3. Community Competencies									
Communities Recognized/Used									
Donor Staff Immersed									
Procedures for Use of Input									
4. Community Skills Enhanced									
Training Programs Available									
PLWHA Empowered Use									

TABLE 12. COMMUNITY OWNERSHIP: INDICATOR PLANNING

Increase Community Ownership	National	Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8
1. Financial Resources Available									
CBO Financing Available									
CBO Capacity Increased									
2. Community Participation									
Leadership Supported									
Community Infrastructure									
Community Monitors									
Supportive Environment									
3. Community Competencies									
Communities Recognized/Used									
Donor Staff Immersed									
Procedures for Use of Input									
4. Community Skills Enhanced									
Training Programs Available									
PLWHA Empowered Use									

TABLE 13. COMMUNITY OWNERSHIP: DONOR ANALYSIS WORKSHEET

Increase Community Ownership	Donor 1	Donor 2	Donor 3	Donor 4	Donor 5	Donor 6	Donor 7	Donor 8
1. Financial Resources Available								
CBO Financing Available								
CBO Capacity Increased								
2. Community Participation								
Leadership Supported								
Community Infrastructure								
Community Monitors								
Supportive Environment								
3. Community Competencies								
Communities Recognized/Used								
Donor Staff Immersed								
Procedures for Use of Input								
4. Community Skills Enhanced								
Training Programs Available								
PLWHA Empowered Use								

4.4 Human Resource Losses Due to HIV/AIDS Are Redressed

5.4.1. Work Place, Employer-Based Responsibility and Initiatives for Prevention, Care and Mitigation is Catalyzed and Sustained

Through studies, research, and personal experience, many employers in developing countries have become aware of the impact of the epidemic on their work force. The issue has been debated in legislative settings, and some countries have undertaken macro analyses of the impact of AIDS mortality and morbidity on their personnel and productive costs. Programs need to be expanded to additional work sites in countries where they have taken hold. They also need to be expanded in countries which have less experience because they will be a major key to sustaining prevention and care programs over the long term. Work place programs can include provision of information and education, peer counseling, condom sales, and STI treatment, and in some areas has been expanded by employers to include free community education and health care provision. The best way to catalyze interventions is to demonstrate their long term cost effectiveness. In some areas, employees have catalyzed and sustained interventions through their own volunteer activities.

5.4.2. Training and Educational System are Reoriented to Respond to Forecasted Gaps

Employers in some developing countries are training as many as three to five individuals for highly skilled jobs to ensure continuity of production in their industries and commercial farms because AIDS mortality has claimed so many of their workers. In other areas, mechanized and less labor intensive alternatives to human labor have been investigated. More employers need to be exposed to possible impacts of the epidemic on their labor supply and alternative responses they might consider. They can be assisted to develop forecasting systems, allocate additional resources, and developing appropriate policies for training and reorientation of their personnel.

5.4.3. Appropriate Redistributions of Labor are Facilitated

Where necessary, individuals whose access to jobs and markets had been low may become viable substitutes for personnel lost to HIV/AIDS. Where necessary, immigration policies may need reexamination and job redesign considered to encourage less labor intensive approaches to meeting productive needs.

Figure 5

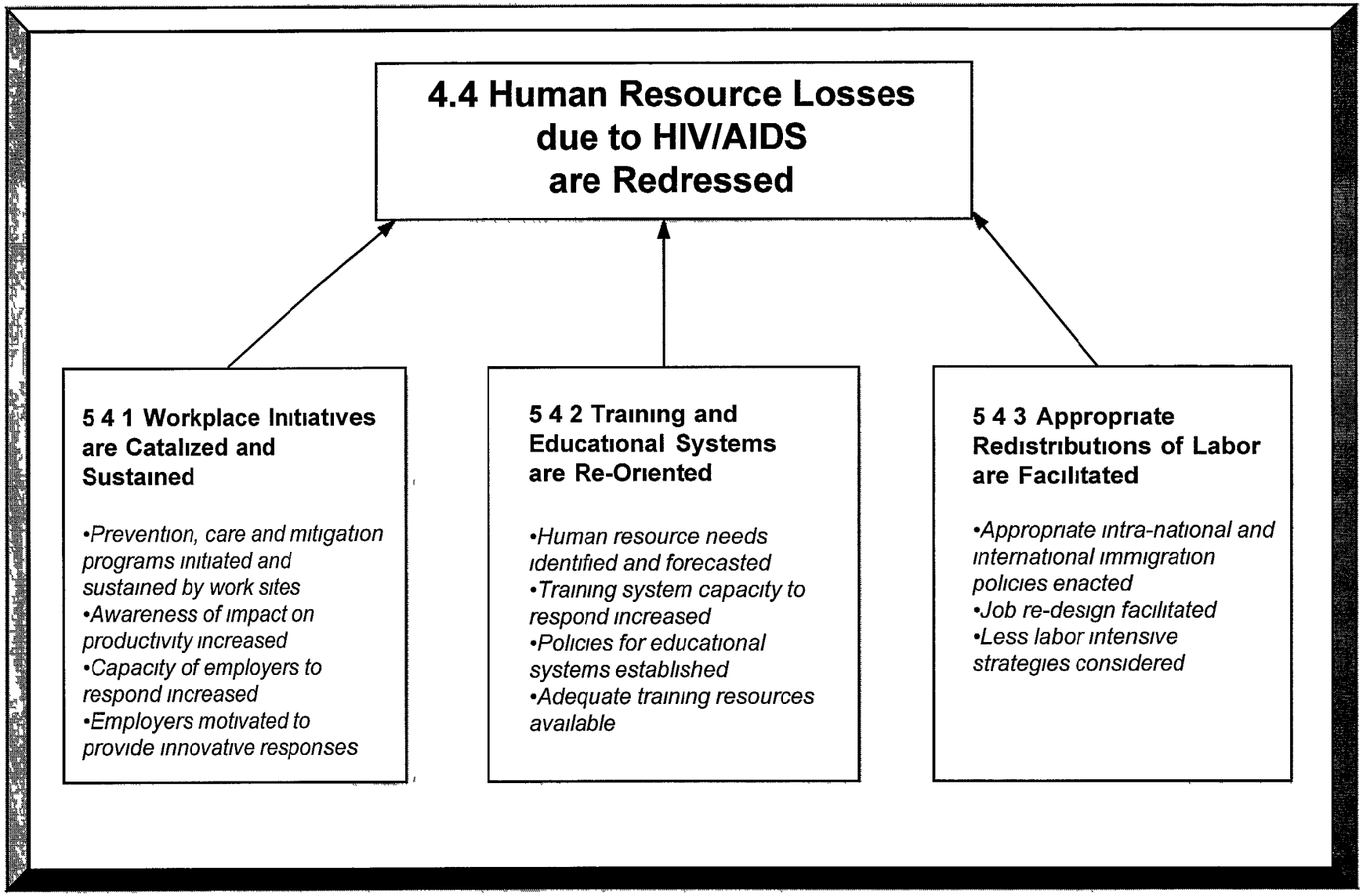
4.4 Human Resource Losses due to HIV/AIDS are Redressed
5 4 1 Workplace Initiatives are Catalized and Sustained
•Prevention, care and mitigation programs initiated and sustained by work sites
•Awareness of impact on productivity increased
•Capacity of employers to respond increased
•Employers motivated to provide innovative responses
5 4 2 Training and Educational Systems are Re-Oriented
•Human resource needs identified and forecasted
•Training system capacity to respond increased
•Policies for educational systems established
•Adequate training resources available
5 4 3 Appropriate Redistributions of Labor are Facilitated
•Appropriate intra-national and international immigration policies enacted
•Job re-design facilitated
•Less labor intensive strategies considered

TABLE 14. IMPLEMENTATION AND INVESTMENT ANALYSIS: HUMAN RESOURCES LOSSES

Human Resource Losses Reduced	Approach	Implementation Mechanisms	Amount Invested
Workplace Programs			
Training/Educational Systems Reoriented			
Redistribution of Labor Facilitated			

TABLE 15. HUMAN RESOURCE LOSS: GEOGRAPHIC PLANNING

Human Resource Loss	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
1. Workplace Initiatives									
Programs in Place, Sustained									
Employer Awareness Increased									
Employer Capacity Increased									
Employers Innovating Responses									
2. Training/Educational Systems									
Needs Forecasted									
Training Capacity in Place									
Educational Policies in Place									
Adequate Resources Available									
3. Labor Redistribution									
Immigration Policies Enacted									
Job Redesign Facilitated									
Less Labor Intensive Strategies Considered									

TABLE 16. HUMAN RESOURCE LOSS: INDICATOR PLANNING

Human Resource Loss	National	Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8
1. Workplace Initiatives									
Programs in Place, Sustained									
Employer Awareness Increased									
Employer Capacity Increased									
Employers Innovating Responses									
2. Training/Educational Systems									
Needs Forecasted									
Training Capacity in Place									
Educational Policies in Place									
Adequate Resources Available									
3. Labor Redistribution									
Immigration Policies Enacted									
Job Redesign Facilitated									
Less Labor Intensive Strategies Considered									

TABLE 17. HUMAN RESOURCE LOSS: DONOR ANALYSIS WORKSHEET

Human Resource Loss	Donor l	Donor 2	Donor 3	Donor 4	Donor 5	Donor 6	Donor 7	Donor 8
1. Workplace Initiatives								
Programs In Place, Sustained								
Employer Awareness Increased								
Employer Capacity Increased								
Employers Innovating Responses								
2. Training/Educational Systems								
Needs Forecasted								
Training Capacity in Place								
Educational Policies in Place								
Adequate Resources Available								
3. Labor Redistribution								
Immigration Policies Enacted								
Job Redesign Facilitated								
Less Labor Intensive Strategies Considered								

7. System Objective 5: Stigma, Discrimination, and Human Rights

4.5 Stigmatization of and Discrimination Against Populations Vulnerable to HIV Are Reduced and Their Human Rights Protected

5.5.1. Supportive Laws and Policies are Developed, Strengthened, and Implemented and Enforced

Reduction of stigmatization and discrimination can play a vital role in maintaining the well being of HIV infected individuals, their families and communities. It is also essential for building community acceptance and support in program planning and design and to mobilize resources. Several approaches have been successful in developing supportive laws and policies. First, on the national level, lawmakers may need education in order to develop laws. Community leaders may need support and education to strengthen local norms against discrimination. Secondly, advocacy groups can be supported to work with formal legal bodies and community leaders on developing broad-based policies. Lastly, independent monitoring systems may be needed to ensure that policies are implemented and enforced.

5.5.2. Understanding of HIV Transmission and Personal Vulnerability is Increased

National, local, and individual support for nondiscrimination will be more easily built and maintained if people understand their risk of infection more accurately. Often, families who were reluctant to accept infected members or care for them change their minds when they understand that their well being is not threatened through everyday contact or by providing simple home care. Peer education campaigns can be an effective mechanism for education, either in the work place, community, or school. Personal risk assessment tools are also useful in building accurate perception of risk.

5.5.3. Community Members and Leaders Advocate and Practice Nondiscriminatory and Supportive Behaviors

Community leaders may be more inclined to advocate acceptance if they are provided with examples of successful implementation of similar policies in other areas. This can be facilitated if mechanisms for advocacy and support are established and sustained. Support groups for PLWHAs are one necessary mechanism to ensure that their voices continue to be heard and respected in developing responses to the epidemic's effects.

5.5.4. Recognition and Acceptance of Intra-Societal Differences is Increased

An important approach to developing community commitment is through sensitization of community leaders to the impact of stigma on the well being of families and individuals and the community as a whole. Dialogue between groups with opposing opinions should be encouraged and sustained. Health care workers can act as leaders in building community acceptance of PLWHAs and their families if they are sensitized to their importance as opinion leaders. Media must be involved early in the development of positive responses and acceptance of their work supported and expanded. In many cases, involvement of PLWHAs in NGO networks will develop and sustain their advocacy skills.

5.5.5. Independent and Effective Monitoring Systems Established and Sustained

Wherever the potential for human rights abuses exists, it is important to have independent watch dog and advisory groups to ensure that abuses do not go unnoticed or unreported. Additionally, as community-based approaches are expanded, community-based protection and sensitization mechanisms must be enhanced to monitor local attitudes and opinions and increase awareness and acceptance.

FIGURE 6

4.5 STIGMA AND DISCRIMINATION

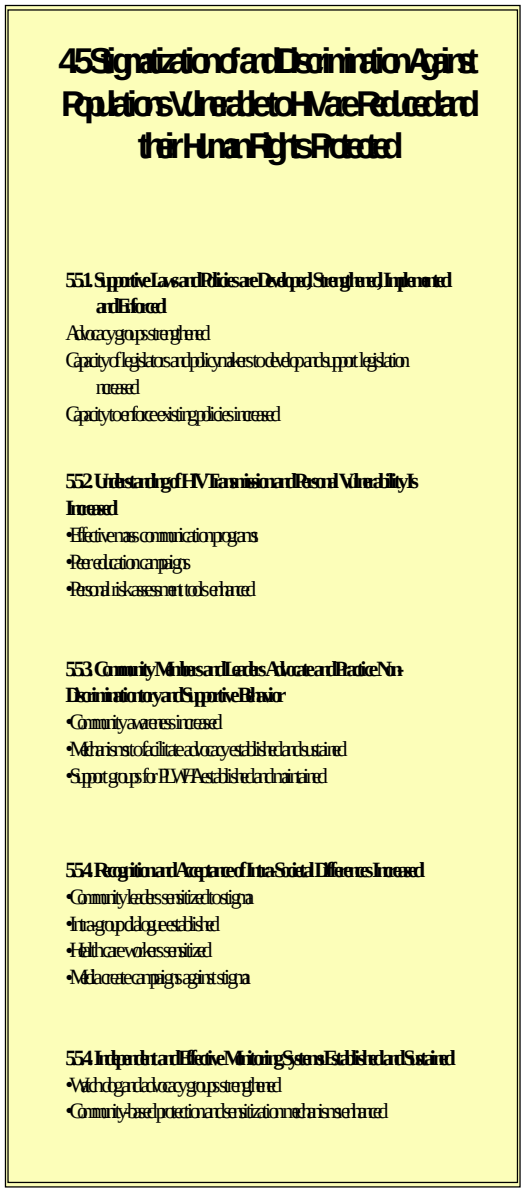

TABLE 18. IMPLEMENTATION AND INVESTMENT ANALYSIS: STIGMA AND DISCRIMINATION

Stigma and Discrimination Reduced	Approach	Implementation Mechanisms	Amount Invested
Supportive Laws and Policies			
Public Understanding			
Community Leaders Sensitized			
Acceptance Increased			
Monitoring Systems			

TABLE 19. STIGMA, DISCRIMINATION, AND HUMAN RIGHTS: GEOGRAPHIC PLANNING

Stigma and Human Rights	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
1. Supportive Laws, Policies									
Advocacy Groups Strengthened									
Legislative Capacity Increased									
Policy Enforcement Capacity									
2. Understanding Increased									
Effective Mass Communication									
Peer Education Programs									
Risk Assessment Tools									
3. Leaders Become Advocates									
Community Awareness									
Mechanisms Established									
Support Groups in Place									
4. Diversity Accepted									
Leaders Sensitized									
Inter-Group Dialogue									

Stigma and Human Rights	National	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8
Health Workers Sensitized									
Media Campaigns									
5. Monitoring Systems in Place									
Advocacy Groups Strengthened									
Community Systems Enhanced									
Educate Infected Persons									

TABLE 20. STIGMA, DISCRIMINATION, AND HUMAN RIGHTS: INDICATOR PLANNING

Stigma and Human Rights	National	Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8
1. Supportive Laws, Policies									
Advocacy Groups Strengthened									
Legislative Capacity Increased									
Policy Enforcement Capacity									
2. Understanding Increased									
Effective Mass Communication									
Peer Education Programs									
Risk Assessment Tools									
3. Leaders Become Advocates									
Community Awareness									
Mechanisms Established									
Support Groups in Place									
4. Diversity Accepted									
Leaders Sensitized									
Inter-Group Dialogue									

Stigma and Human Rights	**National**	**Indicator 1**	**Indicator 2**	**Indicator 3**	**Indicator 4**	**Indicator 5**	**Indicator 6**	**Indicator 7**	**Indicator 8**
Health Workers Sensitized									
Media Campaigns									
5. Monitoring Systems in Place									
Advocacy Groups Strengthened									
Community Systems Enhanced									
Educate Infected Persons									

TABLE 21. STIGMA, DISCRIMINATION, AND HUMAN RIGHTS: DONOR ANALYSIS WORKSHEET

Stigma and Human Rights Protected	Donor 1	Donor 2	Donor 3	Donor 4	Donor 5	Donor 6	Donor 7	Donor 8
1. Supportive Laws, Policies								
Advocacy Groups Strengthened								
Legislative Capacity Increased								
Policy Enforcement Capacity								
2. Understanding Increased								
Effective Mass Communication								
Peer Education Programs								
Risk Assessment Tools								
3. Leaders Become Advocates								
Community Awareness								
Mechanisms Established								
Support Groups in Place								
4. Diversity Accepted								
Leaders Sensitized								
Inter-Group Dialogue								

Stigma and Human Rights Protected	**Donor 1**	**Donor 2**	**Donor 3**	**Donor 4**	**Donor 5**	**Donor 6**	**Donor 7**	**Donor 8**
Health Workers Sensitized								
Media Campaigns								
5. Monitoring Systems in Place								
Advocacy Groups Strengthened								
Community Systems Enhanced								
Educate Infected Persons								